

103^D CONGRESS
2^D SESSION

S. 2196

To assure fairness and choice to patients and providers under managed care health benefit plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 15 (legislative day, JUNE 7), 1994

Mr. WELLSTONE (for himself and Mr. BURNS) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

A BILL

To assure fairness and choice to patients and providers under managed care health benefit plans, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Patient Protection Act
5 of 1994”.

6 **TITLE I—PROTECTION OF**
7 **CONSUMER CHOICE**

8 **SEC. 2. PROTECTION OF CONSUMER CHOICE.**

9 Nothing in this Act shall be construed as prohibit-
10 ing—

1 (1) an individual from purchasing any health
2 care services with the individual's own funds, wheth-
3 er such services are covered within any benefits
4 package otherwise available to the individual; and

5 (2) employers from providing coverage for bene-
6 fits in addition to any benefits package otherwise
7 available to an individual.

8 **TITLE II—CERTIFICATION OF**
9 **MANAGED CARE PLANS AND**
10 **UTILIZATION REVIEW PRO-**
11 **GRAMS**

12 **SEC. 3. DEFINITIONS.**

13 For purposes of this title:

14 (1) **QUALIFIED MANAGED CARE PLAN.**—The
15 term “qualified managed care plan” means a man-
16 aged care plan that the Secretary certifies, upon ap-
17 plication by the program, as meeting the require-
18 ments of section 4(b).

19 (2) **QUALIFIED UTILIZATION REVIEW PRO-**
20 **GRAM.**—The term “qualified utilization review pro-
21 gram” means a utilization review program that the
22 Secretary certifies, upon application by the program,
23 as meeting the requirements of section 4(c).

24 (3) **UTILIZATION REVIEW PROGRAM.**—The term
25 “utilization review program” means a system of re-

1 viewing the medical necessity, appropriateness, or
2 quality of health care services and supplies provided
3 under a health insurance plan or a managed care
4 plan using specified guidelines. Such a system may
5 include preadmission certification, the application of
6 practice guidelines, continued stay review, discharge
7 planning, preauthorization of medical procedures,
8 and retrospective review.

9 (4) MANAGED CARE PLAN.—

10 (A) IN GENERAL.—The term “managed
11 care plan” means a plan operated by a man-
12 aged care entity (as defined in subparagraph
13 (B)), that provides for the financing and deliv-
14 ery of health care services to persons enrolled in
15 such plan through—

16 (i) arrangements with selected provid-
17 ers to furnish health care services;

18 (ii) explicit standards for the selection
19 of participating providers;

20 (iii) organizational arrangements for
21 ongoing quality assurance, utilization re-
22 view programs, and dispute resolution; and

23 (iv) financial incentives for persons
24 enrolled in the plan to use the participat-

1 ing providers and procedures provided for
2 by the plan.

3 (B) MANAGED CARE ENTITY.—The term
4 “managed care entity” includes a licensed in-
5 surance company, hospital or medical service
6 plan, health maintenance organization, an em-
7 ployer or employee organization, or a managed
8 care contractor (as defined in subparagraph
9 (C)), that operates a managed care plan.

10 (C) MANAGED CARE CONTRACTOR.—The
11 term “managed care contractor” means a per-
12 son that—

13 (i) establishes, operates, or maintains
14 a network of participating providers;

15 (ii) conducts or arranges for utiliza-
16 tion review activities; and

17 (iii) contracts with an insurance com-
18 pany, a hospital or medical service plan, an
19 employer, an employee organization, or any
20 other entity providing coverage for health
21 care services to operate a managed care
22 plan.

23 (5) PARTICIPATING PROVIDER.—The term
24 “participating provider” means a physician, hospital,
25 pharmacy, laboratory, or other appropriately author-

1 ized provider of health care services or supplies, that
2 has entered into an agreement with a managed care
3 entity to provide such services or supplies to a pa-
4 tient enrolled in a managed care plan.

5 (6) SECRETARY.—The term “Secretary” means
6 the Secretary of Health and Human Services.

7 **SEC. 4. CERTIFICATION OF MANAGED CARE PLANS AND**
8 **UTILIZATION REVIEW PROGRAMS.**

9 (a) IN GENERAL.—

10 (1) CERTIFICATION.—The Secretary shall es-
11 tablish a process for certification of managed care
12 plans meeting the requirements of subsection (b)
13 and utilization review programs meeting the require-
14 ments of subsection (c).

15 (2) REVIEW AND RECERTIFICATION.—The Sec-
16 retary shall establish procedures for the periodic re-
17 view and recertification of qualified managed care
18 plans and qualified utilization review programs.
19 Such procedures shall include steps by which a
20 health plan may remedy any deficiencies cited.

21 (3) TERMINATION OF CERTIFICATION.—If the
22 Secretary determines that a qualified managed care
23 plan or qualified utilization review program no
24 longer substantially meets the applicable require-
25 ments for certification, the Secretary shall establish

1 procedures for terminating the certification of the
2 plan or program for reasons including the failure of
3 remedies for deficiencies referred to in paragraph
4 (2). Prior to the date a termination becomes effective,
5 the Secretary shall provide the plan notice and
6 opportunity for a hearing on the proposed termination.
7

8 (4) CERTIFICATION THROUGH ALTERNATIVE
9 REQUIREMENTS.—

10 (A) CERTAIN ORGANIZATIONS RECOGNIZED.—An eligible organization (as defined in
11 section 1876(b) of the Social Security Act),
12 shall be deemed to meet the requirements of
13 subsection (b) for certification as a qualified
14 managed care plan.
15

16 (B) RECOGNITION OF ACCREDITATION.—If
17 the Secretary finds that a State licensure program or a national accreditation body establishes
18 requirements for accreditation of a managed care plan or utilization review program
19 that are at least equivalent to requirements established under this section, the Secretary may,
20 to the extent appropriate, treat a managed care plan or a utilization review program accredited
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1 by such program or body as meeting the appli-
2 cable requirements of this section.

3 (b) REQUIREMENTS FOR CERTIFICATION OF MAN-
4 AGED CARE PLANS.—

5 (1) IN GENERAL.—The Secretary shall establish
6 Federal standards for the certification of managed
7 care plans, including standards which require man-
8 aged care plans to meet the requirements described
9 in paragraphs (2) through (6).

10 (2) INFORMATION ON TERMS OF PLAN.—Man-
11 aged care plans shall provide prospective enrollees
12 information on the terms and conditions of the plan
13 so that the enrollees can make informed decisions
14 about accepting a certain system of health care de-
15 livery. Easily understood, truthful, linguistically ap-
16 propriate and objective terms must be used in all
17 oral and written descriptions of a plan. Such de-
18 scriptions shall be consistent with standards devel-
19 oped for supplemental insurance coverage under title
20 XVIII of the Social Security Act. Descriptions of
21 plans under this paragraph must be standardized so
22 that customers can compare the attributes of the
23 plans. Specific items that must be included in a de-
24 scription of a plan are—

1 (A) coverage provisions, benefits, and any
2 exclusions by category of service, provider, or
3 physician, and if applicable, any exclusions by
4 specific service;

5 (B) any and all prior authorization or
6 other review requirements including
7 preauthorization review, concurrent review,
8 post-service review, post-payment review and
9 any procedures that may lead the patient to be
10 denied coverage for, or not be provided, a par-
11 ticular service;

12 (C) financial arrangements or contractual
13 provisions with hospitals, utilization review or-
14 ganizations, physicians, or any other provider of
15 health care services that would limit the serv-
16 ices offered, restrict referral or treatment op-
17 tions, or negatively affect a physician's fidu-
18 ciary responsibility to patients, including finan-
19 cial incentives not to provide medical or other
20 services;

21 (D) an explanation of how plan limitations
22 impact enrollees, including information on en-
23 rollee financial responsibility for payment for
24 coinsurance or other noncovered or out-of-plan
25 services;

1 (E) the plan's loss ratios and an expla-
2 nation that they reflect the percentage of pre-
3 miums expended for health services; and

4 (F) enrollee satisfaction statistics, includ-
5 ing reenrollment statistics and a description of
6 enrollees' reasons for leaving the plan.

7 (3) ADEQUATE ACCESS TO PHYSICIANS.—Man-
8 aged care plans shall be required to demonstrate
9 that they have adequate access to physicians and
10 other providers so that all covered health care serv-
11 ices will be provided in a timely manner. This re-
12 quirement may not be waived and must be met in
13 all areas where the plan has enrollees, including
14 rural areas.

15 (4) FINANCIAL RESERVES.—Managed care
16 plans shall be required to meet financial reserve re-
17 quirements that are established to assure proper
18 payment for health care services provided under the
19 plan. The Secretary shall establish a mechanism to
20 provide adequately for indemnification of plan fail-
21 ures even when a plan has met the reserve require-
22 ments.

23 (5) PROVIDER INPUT.—Managed care plans
24 shall be required to establish a mechanism under
25 which physicians and other providers participating in

1 a plan have defined rights to provide input into the
2 plan's medical policy (including coverage of new
3 technology and procedures), utilization review cri-
4 teria and procedures, quality and credentialing cri-
5 teria, and medical management procedures.

6 (6) CREDENTIALS FOR PHYSICIANS.—

7 (A) IN GENERAL.—Managed care plans
8 shall be required to credential physicians fur-
9 nishing health care services under the plan. Any
10 physicians within a plan's geographic service
11 area may apply for credentials under the plan
12 and at least once each year, the plan shall no-
13 tify such physicians of the opportunity to apply
14 for credentials.

15 (B) CREDENTIALING PROCESS.—

16 (i) IN GENERAL.—Each managed care
17 plan shall establish a credentialing process.
18 Such process shall begin upon application
19 by a physician to be included under the
20 plan. Each application by a physician shall
21 be reviewed by a credentialing committee
22 with appropriate representation of the ap-
23 plicant's medical specialty.

24 (ii) STANDARDS.—Credentialing
25 under a plan shall be based on objective

standards of quality with input from physicians credentialed by the plan. Credentialing standards shall be available to applicants and enrollees.

(iii) ECONOMIC CONSIDERATIONS.—If economic considerations, including practitioners' patterns of expenditure per patient, are part of a credentialing decision, objective criteria must be used in examining such considerations and such criteria must be available to applicants, participating physicians, and enrollees. Any economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher or lower than expected costs. Economic profiles must be made available to the physicians profiled.

(iv) GRADUATE MEDICAL EDUCATION.—If graduate medical education is a consideration in credentialing, equal recognition will be given to training programs accredited by the Accrediting Council on

1 Graduate Medical Education and by the
2 American Osteopathic Association.

3 (v) RECORDING DECISIONS.—A record
4 shall be maintained of all decisions made
5 under the credentialing process and each
6 applicant shall be provided with reasons
7 for an application being denied or a con-
8 tract not being renewed.

9 (vi) DUE PROCESS.—Prior to initi-
10 ation of a proceeding leading to termi-
11 nation of a contract, the physician shall be
12 provided notice, an opportunity for discus-
13 sion, and an opportunity to enter into and
14 complete a corrective action plan, except in
15 cases where there is imminent harm to pa-
16 tient health or an action by a State medi-
17 cal board or other government agency that
18 effectively impairs the physician's ability to
19 practice medicine.

20 (vii) REDUCING OR WITHDRAWING
21 CREDENTIALS.—The same standards and
22 procedures used for an application for cre-
23 dentials shall also be used in those cases
24 where the plan seeks to reduce or withdraw
25 such credentials.

1 (viii) APPEALS.—There shall be al-
2 lowed a due process appeal from all ad-
3 verse decisions affecting practitioners with
4 whom a plan has contracted. The due proc-
5 ess appeal mechanisms shall be as set forth
6 in the Health Care Quality Improvement
7 Act of 1986 (42 U.S.C. 11101–11152).

8 (C) DISCRIMINATION AGAINST ENROLL-
9 EES.—Managed care plans shall be prohibited
10 from discriminating against enrollees based on
11 health status or anticipated need for medical
12 services likely to lead to high expenses by ex-
13 cluding practitioners with practices containing a
14 substantial number of such patients.

15 (7) CONFIDENTIALITY OF RECORDS.—Managed
16 care plans shall be required to establish procedures
17 to ensure that all applicable Federal and State laws
18 designed to protect the confidentiality of provider
19 and individual medical records are followed.

20 (c) REQUIREMENTS FOR CERTIFICATION OF UTILI-
21 ZATION REVIEW PROGRAMS.—

22 (1) IN GENERAL.—The Secretary shall establish
23 Federal standards for the certification of utilization
24 review programs, including standards which require

1 such programs to meet the requirements described
2 in paragraph (2).

3 (2) REQUIREMENTS.—Plans must have a medi-
4 cal director responsible for all clinical decisions by
5 the plan and provide assurances that the medical re-
6 view or utilization practices used by the plans, and
7 the medical review or utilization practices of payers
8 or reviewers with whom the plans contract, comply
9 with the following requirements:

10 (A) Screening criteria used in the review
11 process, the methods by which they are applied,
12 and their method of development, must be re-
13 leased to physicians and the public upon re-
14 quest.

15 (B) Such criteria and methods must be
16 based on sound scientific principles and devel-
17 oped in cooperation with practicing physicians
18 and other affected health care providers.

19 (C) Any person who recommends denial of
20 coverage or payment, or determines that a serv-
21 ice should not be provided, based on medical ne-
22 cessity standards, must be of the same medical
23 branch (allopathic or osteopathic medicine) and
24 specialty (specialties as recognized by the Amer-
25 ican Board of Medical Specialties or the Amer-

1 ican Osteopathic Association) as the practi-
2 tioner who provided the service.

3 (D) Each claimant or provider (upon as-
4 signment of a claim) who has had a claim de-
5 nied as not medically necessary must be pro-
6 vided an opportunity for a due process appeal
7 to a medical consultant or peer review group
8 that is independent of the entity that performed
9 the initial review.

10 (E) Any individual making a final, nega-
11 tive judgment or recommendation about the ne-
12 cessity or appropriateness of services or the site
13 of service must be a comparably qualified health
14 care professional licensed to practice in the ju-
15 risdiction from which the claim arose.

16 (F) Upon request, physicians and other
17 professionals will be provided the names and
18 credentials of all individuals conducting medical
19 necessity or appropriateness review, subject to
20 reasonable safeguards and standards.

21 (G) Prior authorization shall not be re-
22 quired for emergency care, and patient or phy-
23 sician requests for prior authorization of a non-
24 emergency service must be answered within 24
25 hours and qualified personnel must be available

1 for same-day telephone responses to inquiries
2 about medical necessity, including certification
3 of continued length of stay. If review personnel
4 are not available, medical services provided
5 shall be considered approved.

6 (H) Plans must ensure that enrollees, in
7 plans where prior authorization is a condition
8 for coverage of a service, are offered the oppor-
9 tunity to sign medical information release con-
10 sent forms upon enrollment for use where serv-
11 ices requiring prior authorization are rec-
12 ommended or proposed by their physician.

13 (I) When prior approval for a service or
14 other covered item is obtained, the service shall
15 be considered to be covered unless there was
16 fraud or incorrect information provided at the
17 time such prior approval was obtained.

18 (J) Plans must establish procedures for
19 ensuring that all applicable Federal and State
20 laws designed to protect the confidentiality of
21 provider and individual medical records are fol-
22 lowed.

23 (d) CONSIDERATIONS IN DEVELOPING STAND-
24 ARDS.—In developing standards under subsections (b) and
25 (c), the Secretary shall—

1 (1) review standards in use by national private
2 accreditation organizations and State licensure pro-
3 grams;

4 (2) recognize, to the extent appropriate, dif-
5 ferences in the organizational structure and oper-
6 ation of managed care plans; and

7 (3) establish procedures for the timely consider-
8 ation of applications for certification by managed
9 care plans and utilization review programs.

10 (e) TIMETABLE FOR ESTABLISHMENT OF STAND-
11 ARDS.—

12 (1) IN GENERAL.—Not later than 12 months
13 after the date of the enactment of this Act standards
14 shall first be established under this section.

15 (2) REVISION OF STANDARDS.—The Secretary
16 shall periodically review the standards established
17 under this section, and may revise the standards
18 from time to time to assure that such standards con-
19 tinue to reflect appropriate policies and practices for
20 the cost-effective and medically appropriate use of
21 services within managed care plans and utilization
22 review programs.

1 **TITLE III—CHOICE OF HEALTH**
2 **PLANS FOR ENROLLMENT**

3 **SEC. 5. CHOICE OF HEALTH PLANS FOR ENROLLMENT.**

4 (a) IN GENERAL.—Each sponsor, including a self-in-
5 sured sponsor, of a health benefit plan, who offers, pro-
6 vides, or makes available such plan must provide to each
7 eligible enrollee a choice of health plans among available
8 plans.

9 (b) OFFERING OF PLANS.—Each sponsor referred to
10 in subsection (a) shall include among its health plan offer-
11 ings at least one of each of the following types of health
12 benefit plans, where available:

13 (1) A managed care plan, including a health
14 maintenance organization or preferred provider or-
15 ganization.

16 (2) A traditional insurance plan (as defined in
17 subsection (c)(1)).

18 (3) A benefit payment schedule plan (as defined
19 in subsection (c)(2)), pursuant to the following ac-
20 tivities of the Secretary:

21 (A) Not later than 12 months after the
22 date of the enactment of this Act, the Secretary
23 shall—

24 (i) conduct a study on the projected
25 impact of benefit payment schedule plans

1 on enrollees and on the Nation's health
2 care costs; and

3 (ii) submit a report to Congress on
4 the results of such study.

5 (B) The Secretary shall promulgate regula-
6 tions to—

7 (i) assure that benefit payment sched-
8 ule plans, if approved, are affordable for
9 all enrollees and contribute to health care
10 cost containment; and

11 (ii) remedy any other significant defi-
12 ciencies identified by the study described in
13 subparagraph (A).

14 (c) DEFINITIONS.—For purposes of this section:

15 (1) TRADITIONAL INSURANCE PLAN.—The term
16 “traditional insurance plan” includes plans that
17 offer a health benefits package and that pay for
18 medical services on a fee-for-service basis using a
19 usual, customary, or reasonable payment methodol-
20 ogy or a resource based relative value schedule, usu-
21 ally linked to an annual deductible and/or coinsur-
22 ance payment on each allowed amount.

23 (2) BENEFIT PAYMENT SCHEDULE PLAN.—The
24 term “benefit payment schedule plan” means a
25 health plan that—

1 (A) provides coverage for all items and
2 services included in a health benefits package
3 that are furnished by any health care provider
4 licensed under State law of the enrollee's
5 choice;

6 (B) makes payment for the services of a
7 provider on a fee-for-service basis without re-
8 gard to whether or not there is a contractual
9 arrangement between the plan and the provider;

10 (C) provides a benefit payment schedule
11 that identifies covered services and the payment
12 for each service covered by the plan; and

13 (D) applies no copayments or coinsurance.

14 **SEC. 6. CHOICE REQUIREMENTS FOR POINT-OF-SERVICE**
15 **PLANS.**

16 (a) IN GENERAL.—Each sponsor, including a self-in-
17 sured sponsor, of a health benefit plan that restricts access
18 to providers, shall offer to all eligible enrollees the oppor-
19 tunity to obtain coverage for out-of-network items or serv-
20 ices through a point-of-service plan (as defined under sub-
21 section (e)(1)), at the time of enrollment and at least for
22 a continuous one-month period annually thereafter.

23 (b) COINSURANCE.—A point-of-service plan may re-
24 quire payment of coinsurance for an out-of-network item
25 or service, as follows:

1 (1) The applicable coinsurance percentage shall
2 not be greater than 20 percent of payment for items
3 and services.

4 (2) The applicable coinsurance percentage may
5 be applied differentially with respect to out-of-net-
6 work items and services, subject to the requirements
7 of paragraph (1).

8 (c) PAYMENT DISCLOSURE REQUIREMENT.—All
9 sponsors of point-of-service plans and physicians and other
10 professionals participating in such plans shall be required
11 to disclose their fees, applicable payment schedules, coin-
12 surance requirements, or any other financial requirements
13 that affect patient payment levels.

14 (d) POVERTY EXCLUSION.—Any enrollee, including
15 enrolled dependents, whose income does not exceed 200
16 percent of the established Federal poverty guideline for
17 the applicable year, shall be charged no more than the
18 amount allowed under applicable plan limits. Such amount
19 shall be considered payment in full.

20 (e) DEFINITIONS.—For purposes of this section:

21 (1) POINT-OF-SERVICE PLAN.—The term
22 “point-of-service plan” means a plan that offers
23 services to enrollees through a provider network (as
24 defined in paragraph (2)) and also offers additional

1 services and/or access to care by network or non-net-
2 work providers.

3 (2) PROVIDER NETWORK.—The term “provider
4 network” means, with respect to a health plan that
5 restricts access, those providers who have entered
6 into a contract or agreement with the plan under
7 which such providers are obligated to provide items
8 and services under the plan to eligible individuals
9 enrolled in the plan, or have an agreement to pro-
10 vide services on a fee-for-service basis.

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